AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

March 21, 2012

Quick Links

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Announcements

Primary Care Training and Enhancement Interdisciplinary and Inter-professional Joint Graduate Degree Program, §5301. Announced March 16, 2012. Funding is available to plan, develop and operate an Interdisciplinary and Inter-professional Joint Graduate Degree Program that supports the integration of public health and primary care graduate education. Eligible applicants are accredited public or nonprofit private hospitals, schools of allopathic medicine or osteopathic medicine, and academically affiliated physician assistant training programs. $2.5M in 8 five-year grants is available for this initiative. Applications are due April, 19, 2012.
The announcement can be viewed at: HRSA

Initiative Announced to Reduce Avoidable Hospitalizations among Nursing Facility Residents, §3021. Announced March 15, 2012. This initiative aims to improve the quality of care for people residing in nursing facilities. CMS will support organizations that partner with nursing facilities to implement evidence-based interventions that both improve care and lower costs. The initiative is focused on long-stay nursing facility residents who are enrolled in the Medicare and Medicaid programs (known as duals), with the goal of reducing avoidable inpatient hospitalizations. Through this initiative, CMS will partner with eligible, independent, non-nursing facility organizations (referred to as "enhanced care and coordination providers") to implement and test evidence-based interventions that reduce avoidable hospitalizations. Eligible organizations can include physician practices, care

management organizations, and other public and not-for-profit entities. The enhanced care and coordination providers will collaborate with states and nursing facilities, with each enhanced care and coordination provider implementing its intervention in at least 15 partnering nursing facilities. Successful applicants will implement such interventions that will have the following objectives: 1) Reduce the frequency of avoidable hospital admissions and readmissions; 2) Improve resident health outcomes; 3) Improve the process of transitioning between inpatient hospitals and nursing facilities; and 4) Reduce overall health care spending without restricting access to care or choice of providers. The interventions will primarily target long-stay dual enrollees in Medicare-Medicaid certified nursing facilities, rather than those likely to experience only a brief post-acute stay and then return home.

Interventions will be evaluated for their effectiveness in improving health outcomes and providing residents with a better care experience. Total Initiative funding is up to $128 million. CMS expects to make approximately seven awards, ranging from $5 million to $30 million each to cover a four-year cooperative agreement period of performance from August 25, 2012 through August 24, 2016. CMS anticipates making cooperative agreements awards by August 23, 2012.
Applications are due June 14, 2012.
The announcement can be viewed at: Grants.gov
Read the fact sheet at:
http://innovation.cms.gov/Files/fact-sheet/rahnfr-factsheet.pdf
For more information visit:
http://innovation.cms.gov/initiatives/rahnfr/

Guidance

3/19/12 Department of Labor posted a 8th set of FAQ's regarding implementation of the summary of benefits and coverage (SBC) provisions of the ACA. These FAQ's have been prepared jointly by the Departments of Health and Human Services (HHS), Labor and the Treasury. Like previously issued FAQ's (available at www.dol.gov/ebsa/healthreform/), these FAQ's answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

The final SBC rule implements the disclosure requirements, as added by §10101(b) of the ACA, which require plans to provide concise and comprehensible coverage information to the millions of Americans with private health coverage so that they can more easily directly compare one plan to another.
The SBC FAQ's can be found at:
http://www.dol.gov/ebsa/faqs/faq-aca8.html
The sample SBC completed by the Departments is available at:
www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf
Read the final SBC rule at: http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228

3/16/12 HHS released a notice of advance rulemaking with 90-day comment period regarding Certain Preventive Services Under the ACA.
The notice outlines draft proposals to implement a policy announced by President Obama and HHS Secretary Sebelius in February 2012 regarding §2713 of the ACA that guarantees women will have free preventive care that includes contraceptive services no matter where they work while protecting religious liberty and accommodating concerns raised by faith-based employers. ACA §2713 requires that most private health plans cover preventive services for women including recommended contraceptive services without charging a co-pay, co-insurance or a deductible in new private health plans in plan years that start on or after August 1, 2012.
On 1/20/12 HHS announced a rule that exempted organizations that are faith-based and primarily employ those of the same faith (such as churches, synagogues and mosques) from

the requirement. A transition period was announced that would allow faith-based nonprofits an extra year to begin covering contraceptives. The regulation finalized on 2/10/12 will require insurance companies to cover contraception if the non-exempted religious organization chooses not to. Under the policy: 1) Religious organizations will not have to provide contraceptive coverage or refer their employees to organizations that provide contraception. 2) Religious organizations will not be required to subsidize the cost of contraception. 3) Contraception coverage will be offered to women by their employers' insurance companies directly, with no role for religious employers who oppose contraception. And 4) Insurance companies will be required to provide contraception coverage to these women free of charge.

HHS is seeking comments, which are due **June 19, 2012**, on ways to amend the final rule published in February 2012 that would establish alternative ways to fulfill the requirements of §2713 when health coverage is sponsored or arranged by a religious organization that objects to the coverage of contraceptive services for religious reasons and that is not exempt under the final regulations. The notice says that HHS intends to propose that a third-party administrator (TPA) of a group health plan or some other independent entity would be responsible for the provision of contraceptive coverage without cost-sharing to individuals receiving coverage from certain religious employers that self-insure.

In the notice HHS suggested that the TPA could use revenue that is not already obligated to health plan sponsors such as drug rebates, service fees, disease management program fees or other sources to fund the contraceptive coverage without using funds provided by the religious organization. The administration, seeking comment on the potential funding approaches, is also considering the following possible approaches for TPAs to administer the contraceptive benefit without the religious employer incurring the costs: The TPA could receive a credit or rebate on the amount that it pays under the health reform law's reinsurance program, or the TPA could arrange for contraceptive coverage through another separate independent entity, such as a private insurer contracting with the Office of Personnel Management to offer a multi-state plan in insurance exchanges.
Read the press release at: http://www.hhs.gov/news/press/2012pres/03/20120316g.html
Read the Advance Notice of Proposed Rulemaking at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-21/pdf/2012-6689.pdf
Read the final rule (published on 2/15/12) for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act at: Final Day

3/16/12 HHS/CMS announced the final rule which establishes the requirements for Student Health Insurance Coverage under ACA§1560(c). The final rule defines this coverage as a type of individual health insurance coverage and specifies that, as a result, certain consumer protections and preventive services coverage are applicable. Students enrolled in student health insurance coverage will benefit from other ACA individual market protections, including: the prohibition against rescissions of coverage (§2712), the prohibition against lifetime dollar limits (§2711), the dependents under 26 coverage requirements (§1001), preventive services (§2713) and other patient protections (§2719A). Under §1001, students must also be notified that they may be eligible for health coverage as a dependent under their parents' employer plan or individual market coverage if they are under the age of 26. The student health plan rule makes some adjustments to consumer protections in the ACA including certain adjustments to the annual dollar limits requirements under §2711 and medical loss ratio (MLR) requirements under §10101 for health plans providing for transition periods for issuers of plans to comply with the ACA. For example, short-term exceptions to the restricted annual dollar limits requirements under the ACA state that student health plans cannot have a yearly dollar coverage limit less than $100,000 for the 2012 school year, which increases to $500,000 the 2013 school year, so that by January 1, 2014 annual limits are prohibited as required by the ACA. Similar to limited benefit plans and expatriate plans, the MLR adjustment will,

according to HHS, address the unusual expense associated with administering student health plans and premium structures of student health plans. These changes to the methodology for reporting and rebates apply only in calendar year 2013; after that plans must comply with the MLR standards under the ACA.

HHS said that student health plans will be treated like employees' plans, meaning they will have to comply with new requirements under the ACA, including the requirement to provide contraception without charging a copayment. The final rule notes that self-funded student health plans are not included in this regulation and clarifies that the student health plans of non-profit religious institutions of higher education qualify for a one-year transition from the new contraceptive coverage requirement, similar to non-profit employers. Furthermore, religious universities will treat their student plans the same as their employees' plans, and will not be required to directly offer contraception in their plans, but students and workers will be able to get birth control from their insurance companies without a copayment.
Read the fact sheet at:

http://www.healthcare.gov/news/factsheets/2012/03/student-health-plans03162012a.html
Read the final rule at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-21/pdf/2012-6359.pdf

3/16/12 CMS announced the final "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010" rule. The final rule implements several provisions of the Affordable Care Act including §2001, §2002, §2202, §1413, and §1414 related to Medicaid eligibility, enrollment and coordination with the Health Insurance Exchanges, the Children's Health Insurance Program (CHIP), and other insurance affordability programs. It also simplifies the current eligibility rules and systems in the Medicaid and CHIP programs. The final rule: (1) reflects the statutory minimum Medicaid income eligibility level of 133% FPL across the country for most non-disabled adults under age 65; (2) eliminates obsolete eligibility categories and collapses other categories into four primary groups: children, pregnant women, parents, and a new adult group; (3) modernizes eligibility verification rules to rely primarily on electronic data sources; (4) codifies the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for most individuals; and (5) ensures coordination across Medicaid, CHIP, and the Exchanges. In response to public comment, the final rule clarifies that people with disabilities or in need of long-term services and supports may enroll in an existing Medicaid eligibility category to ensure that they are quickly enrolled in coverage that best meets their needs.

In response to comments from states, the final Medicaid rule also outlines two options for how state Medicaid and CHIP agencies and exchanges can coordinate eligibility determinations for Medicaid and other insurance affordability programs. The final rule says that state Medicaid and CHIP agencies can make the final eligibility determinations based on the exchange's initial review; or, the state Medicaid and CHIP agencies can accept a final eligibility determination made by an exchange that uses state eligibility rules and standards.

The final Medicaid Eligibility rule does not address changes in the Federal Medical Assistance Percentage (FMAP) rates. According to CMS, a separate final FMAP rule is expected around October 2012, as technical work with states on FMAP methodologies and income conversion continues.

CMS also announced that certain provisions of the final rule regarding coordinated eligibility and enrollment among insurance affordability programs are being issued as an interim final rule and are open to public comment for 45 days after publication in the Federal Register on March 27, 2012.
Read the final rule at:
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/REG-03-16-12.pdf

Read the fact sheet at: Medicaid.Gov
Read the final regulatory impact analysis at: Medicaid.Gov
Read the press release at:
http://www.hhs.gov/news/press/2012pres/03/20120316a.html

3/16/12 HHS announced the final "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" rule. The final rule implements standards under §1341, §1342, §1343 of the ACA for states related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment. The ACA set up three risk-mitigation programs to offset market uncertainty and risk selection to maintain the viability of exchanges. These programs will mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Exchanges launch in 2014. This rule gives states options in designing and administering these programs. The transitional state-based reinsurance program serves to reduce uncertainty by sharing risk in the individual market through making payments for high claims costs for enrollees. The temporary federally administered risk corridors program serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the federal government. The permanent state-based risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as individuals with chronic conditions).
Read the final rule (which was published in the Federal Register on March 23, 2012) at:
http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf
Read the fact sheet at:
http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html
Read the final regulatory impact statement at:
http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf

Prior guidance can be viewed at www.healthcare.gov

News

3/19/12 Nancy-Ann DeParle, Deputy Chief of Staff and former Director of the White House Office of Health Reform, held "Office Hours" on Twitter, answering questions about the ACA from a variety of Americans. Read the question and answer feed at:
http://storify.com/whitehouse/wh-office-hours-with-nancy-ann-deparle-3-19-12

3/19/12 White House Press Secretary Jay Carney fielded questions on a range of topics during an online engagement series, utilizing social media. He responded to questions on a variety of topics, including the ACA. To check out his response, visit:
Whitehouse.Gov

On Friday, 3/23/12 at 2:00 p.m. EST, Cecilia Muñoz, Director of the Domestic Policy Council, will also answer health care questions on Twitter. Here is how you can join the conversation:

- Ask your question on Twitter with the hashtag #WHChat
- White House officials answers your questions from the @WHLive account
- Follow the Q&A through the @WHLive Twitter account and the hashtag #WHChat
- If you miss the live event, the full session will be posted on WhiteHouse.gov and Storify.com/WhiteHouse

3/19/12 CMS announced that as a result of the ACA, over 5.1 million seniors and people with disabilities with **Medicare Part D who reached the gap in coverage known as the "donut hole"** have received an automatic discount on their prescription drugs. CMS data show 102,541 Medicare beneficiaries have benefitted from the discount in the first two months of

2012. In Massachusetts, as of February 29, 2012, 1,681 individuals had received an average discount amount per beneficiary of $983.09. Last year, the ACA provided a 7% discount on covered generic medications for people who hit the donut hole. This year members will save 14% discount on generics. Beneficiaries also receive a 50% discount on their covered brand name prescription drugs. In 2010, nearly 4 million beneficiaries who hit the donut hole received a $250 rebate under the ACA to help them afford prescription drugs in the coverage gap. These discounts will continue to grow over time until the donut hole is closed completely in 2020 as required by ACA §1101.

For more information, visit:
http://www.hhs.gov/news/press/2012pres/03/20120319a.html

For the CMS data, visit: http://www.cms.gov/Plan-Payment/

3/21/12 CMS published a notice regarding the Early Retiree Reinsurance Program (ERRP), a program authorized under §1102 of the ACA which provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and early retirees' spouses, surviving spouses, and dependents, which states that plan sponsors participating in ERRP must use ERRP reimbursement funds as soon as possible but no later than December 31, 2014.

In April 2011 CMS announced that, due to the availability of funds, the agency was exercising its authority under §1102(f) of the ACA to stop accepting applications for the EERP as of May 5, 2011, The EERP fund was established to be available until 2014, when health insurance exchanges are operational and new rules are in effect to make it easier for older Americans to buy insurance without the help of an employer. Congress appropriated $5 billion for the program, but as of February 2012, ERRP has provided $4.73 billion in reinsurance payments to more than 2,800 employers and other sponsors of retiree plans. In December 2011, when reimbursements surpassed the $4.5 billion mark, CMS said it would not pay claims incurred after December 31, 2011, although early retiree health care plan sponsors could continue to file for reimbursement of claims incurred through that date.

Read the March 2012 notice at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-21/pdf/2012-6728.pdf
For more information, visit the ERRP site at: http://errp.gov/newspages/20110401-applications-acceptance.shtml

3/15/12 The Medicaid and CHIP Payment and Access Commission (MACPAC) released a report to Congress on Medicaid and CHIP. The report makes four recommendations: one covering the commission's work on Medicaid enrollees with disabilities, one on the need for changes that improve care and reduce costs, and two on fraud. The commission recommended that federal Medicaid officials and the states focus on developing ways to improve the quality of care for people with disabilities while lowering costs, recommending that caring for beneficiaries with disabilities in ways that promote coordination of physical, behavioral and community support services should be a priority for the CMS Innovation Center. The group called on the HHS Secretary to work with states to simplify outdated and expensive anti-fraud efforts and implement new, effective ways to combat fraud. The MACPAC report also makes recommendations for fee-for-service pay rate categories, including a recommendation to reduce pay for evaluation and maintenance services that are provided in outpatient departments so they are equal to pay rates for those same services provided in doctor offices. The commission also encourages physicians to join accountable care organizations.
MACPAC was established by the Children's Health Insurance Program Reauthorization Act and later expanded and funded through the ACA. MACPAC is tasked with reviewing state and

federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the HHS Secretary, and the states on a wide range of issues affecting Medicaid and CHIP populations, including health care reform.

Read the report at: MACPAC

3/14/12 CMS announced the second round of site selections under the Community-based Care Transition Program (CCTP), §3026 of the ACA, which provides funding from the Innovation Center to demonstrations to community-based organizations partnering with eligible hospitals for care transition services. 23 sites will join the seven organizations announced in November 2011 working with CMS and local hospitals to provide support for high-risk Medicare patients following a hospital discharge as they move to new settings, including skilled nursing facilities and home. Community organizations help patients stay in contact with their doctors to ensure their questions are answered and they are taking medications they need to help them stay healthy. The second round of program participants will support more than 126 local hospitals and help more than 223,000 Medicare beneficiaries in 19 states.

CMS awarded program agreements to recipients that can demonstrate an overall reduction in Medicare expenditures over the program period. CMS did not provide savings estimates from the agreements. CCTP is part of the Partnership for Patients which is charged with reducing hospital-acquired conditions by 40% and hospital readmissions by 20% by 2013. Under the ACA, the CCTP program may spend up to $500 million over five years and with the second round of site selections, CMS announced that the agency has committed half of the $500 million allocated to CCTP. As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high risk for readmission to the hospital.

The second round of site participants are located in Arkansas, Arizona, California, Connecticut, Illinois, Massachusetts, Michigan, Nebraska, New York, Ohio, Pennsylvania, Texas and Washington. Massachusetts sites include: 1) Elder Services of Berkshire County, a Massachusetts-designated Aging Services Access Point (ASAP) and federally-designated AAA in rural western Massachusetts, that will partner with Berkshire Medical Center and the Berkshire Visiting Nurse Association to improve care transition services for Medicare beneficiaries; and 2) Elder Services of Worcester, Massachusetts, a Massachusetts-designated ASAP and federally-designated AAA, that will partner with Bay Path Elder Services. They will provide care transitions services in partnership with seven hospitals, including: MetroWest Medical Center; St. Vincent Hospital; UMass Memorial Medical Center; Wing Memorial Hospital; Marlborough Hospital; Clinton Hospital, and HealthAlliance Hospital.

In November 2011 CMS announced the **first site selections** under this program. This included: 1) Elder Services of the Merrimack Valley, Inc., in partnership with Anna Jacques Hospital, Saints Medical Center, Holy Family Hospital, Lawrence General Hospital, and Merrimack Valley Hospital, and serving 23 cities/towns in the Merrimack Valley of Massachusetts and ten bordering cities/towns in southern New Hampshire where patients using these hospitals also reside.

View a list of the second group of CCTP partner organizations and details about their organizations at: Innovation

The CMS Innovation Center will continue to accept applications as long as funding is available. For more information on how to apply visit: CMS.Gov

For more information about the Community Based Care Transitions Program, visit: http://go.cms.gov/caretransitions

3/13/12 The Congressional Budget Office (CBO) released a revised estimate for the insurance coverage provisions of the ACA. The new analysis estimates that the ACA's insurance coverage provisions will have an approximate cost to taxpayers of just under $1.1 trillion over the next 10 years, which is $50 billion less than it projected for the same time period last March. The CBO is also now projecting that the ACA will reduce the number of uninsured individuals by 30 million instead of 32 million by 2016 as originally figured.

The new CBO analysis increases its estimate of how many people will enroll in Medicaid and the Children's Health Insurance Program (CHIP) under the ACA because of new assumptions showing higher unemployment rates than were previously calculated. According to the analysis, the CBO expects more people to obtain coverage through Medicaid and CHIP, while fewer people will be insured through employers or insurance exchanges.

According to current estimates, from 2016 on, between 20 million and 23 million people will receive coverage through the new health insurance exchanges, and 16 million to 17 million additional people will be enrolled in Medicaid and CHIP as a result of ACA. The CBO also projects that 3 million to 5 million fewer people will have coverage through an employer compared with the number under prior law.

Read the CBO updated budget projections at: CBO.Gov

Read the CBO updated insurance coverage estimates at: CBO.Gov

3/15/12 CBO released a related report updating their estimate of the ACA's effects on the number of people obtaining employment-based health insurance (ESI). Using the baseline projections released earlier this week, the CBO calculates that approximately 3 million to 5 million fewer people will obtain coverage through their employer each year from 2019 through 2022 under the ACA than would have been the case under prior law. Although the analysis states that the ACA will continue to lead to a small reduction in ESI, the CBO does not forecast a sharp decline in ESI as a result of the ACA. The analysis explores several scenarios impacting the estimate including: the share of the workers and their families losing ESI who are eligible for Medicaid, CHIP, or exchange subsidies and on the tax rates those workers pay; whether employers will continue to have an economic incentive to offer health insurance to their employees and how different ESI enrollment estimates may raise or lower the cost of the insurance provisions of the ACA.

Read the CBO estimate of the ACA's effect on ESI at: CBO.Gov

3/13/12 CMS announced that 11 states and the District of Columbia will participate in the Medicaid Emergency Psychiatric Demonstration established under ACA §2707 to test whether Medicaid beneficiaries who are experiencing a psychiatric emergency get more immediate, appropriate care when institutions for mental diseases (IMDs) receive Medicaid reimbursement. The Demonstration is designed to provide states with more flexibility and resources to care for Medicaid beneficiaries with mental illnesses.

The Demonstration, administered by the Center for Medicare and Medicaid Innovation, provides up to $75 million in federal Medicaid matching funds to states over three years to help care for Medicaid patients (aged 21 through 64) with psychiatric emergencies in private inpatient psychiatric facilities that are historically prohibited from receiving Medicaid reimbursement. As a result of this policy, when these Medicaid beneficiaries need emergency psychiatric treatment, they may seek services in general hospital emergency departments where services may not be appropriate or in psychiatric hospitals where the care may be appropriate but reimbursement is not provided. The Demonstration will test whether Medicaid reimbursement to treat psychiatric

emergencies in IMD settings will enable states to increase the quality of care for people needing treatment for mental illness at lower cost, and will also test whether such expanded coverage reduces the burden on general acute care hospital emergency departments.

States awarded demonstration funding include the following: Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia and the District of Columbia.

Read the press release at: CMS.Gov
Additional information can be found at: innovations.cms.gov/initiatives/medicaid-emergency-psychiatric-demo

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals Open Meeting
April 9, 2012, 10:00 AM - 12:00 PM
State Transportation Building, Conference Rooms 1, 2, & 3, Second Floor, 10 Park Plaza, Boston

The purpose of this open meeting will be to discuss next steps in the State Demonstration to Integrate Care for Dual Eligible Individuals, following topical workgroup and other activities occurring in March.

Attendance is welcome from all stakeholders and members of the public with interest in this proposed Demonstration. Reasonable accommodations will be made for participants who need assistance. Please send your request for accommodations to Donna Kymalainen at Donna.Kymalainen@state.ma.us.

Insurance Market Reform Work Group Open Stakeholder Meetings
The Insurance Market Reform Work Group, co-chaired by the Health Connector and the Division of Insurance, is hosting a series of open meetings to solicit feedback on a range of topics under its purview. The meeting schedule and proposed topics are highlighted below. If any interested persons are unable to attend the meetings in person, they can participate in the session by calling the number below. We highly encourage people to attend in person as the acoustics in the Hearing Room can be difficult.
Dialing Instructions:
Dial 1-877-820-7831
Pass Code 9630386# (please make sure to press # after the number).

Research to study the impact of ACA changes to the size of the small group market (from 1-50 to 1-100); and Changes to rating factors (e.g., group size adjustment, age bands, industry code, etc)
March 23, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

Follow-up meeting on Essential Health Benefits approach and options
April 6, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices
Follow-up meeting about research to study the impact of ACA changes to the size of the small group market; and Changes to rating factors (e.g., group size

adjustment, age bands, etc.)
April 27, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

Potential ACA changes including open enrollment/special enrollment, eligibility appeals, termination, uniformity of forms
May 11, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

Other issues (TBD)
May 25, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.